COMMENTARY

A response from Congressman Pete Stark

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Competing interests: None declared

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The Ethics in Patient Referrals Act[1] was originally passed in 1989 to address the then-exploding phenomenon of physicians buying interests in companies to which they would then refer patients for ancillary services. Virtually every study that was conducted concluded that physicians who owned or had other financial relationships with such companies used the services at a substantially higher rate than did physicians without any financial stake. In a fee-for-service world, higher use directly translates into higher health care costs for Medicare and Medicaid.

More than a decade later, fee-for-service payment continues to be the dominant method used by Medicare for paying physicians and providers of ancillary services. In short, the statute is as necessary today as it was in 1989. At the same time, much has changed in health care since the statute was enacted, including the expansion of group practices, increased managed care, and the growth of large health care systems. In anticipation of such changes and in recognition of the complexity of our health care system, the statute gave the Secretary of Health and Human Services substantial discretion to fine tune the department's regulations to achieve the statute's purpose while minimizing unintended collateral effects on the health care system. The final regulations issued in January 2001 strike an appropriate balance between these objectives.

The statute and regulations contain a number of specific exceptions to the general prohibition for nonabusive financial relationships. For example, the law permits physicians to provide designated health services (DHS) to their patients within their own medical practices (known as the in-office ancillary services exception), as long as certain conditions necessary to protect against abuse are satisfied. The Health Care Financing Administration (HCFA) interpreted the statutory exceptions broadly—and added additional exceptions—to provide physicians and DHS providers with substantial flexibility in structuring their relationships. Moreover, the regulations ensure that physicians can always make services available to patients, although not necessarily at a profit for the physician.

Although the regulations may appear complex, they establish 2 general principles. First, a referring physician cannot directly or indirectly own an interest in a DHS provider unless the provider is in a rural area or the DHS is provided through the physician's group or solo practice under the in-office ancillary services exception. Second, any compensation arrangement between a referring physician and a DHS provider or supplier must be at fair market value for items or services actually rendered. These principles, plainly stated in the regulations, establish rules of thumb that can be applied to most arrangements between referring physicians and DHS providers with whom they may have a financial relationship to determine whether a violation exists.

Reference

1 The Ethics in Patient Referrals Act (Stark I) 42 USC §1395nn (1989).

Remember small-town hospitals?

When you saw fresh roses in fruit jars in patients' rooms.

When homemade quilts were spread over the hospital bed.

When the nurse blushed when she gave her former English teacher an enema.

When the hospital gardener came to visit most of the patients.

When a patient walked out the door and pushed his IV caddie across the street to have a glass of iced tea with his friends on their front lawn.

When the doctor made his evening calls with cow manure still on the heels of his cowboy boots and the sweat still damp on his hatband.

When the patient complained about her diet, and the cook, wearing a flour-dusted apron and carrying a wooden spoon, came to explain it to her.

When the new baby's grandma insisted on using belly bands and the doctor didn't think they were necessary. Grandma won. She presented the nursery with a box of bands, hemstitched in pink and blue.*

When the school board met in the hospital cafeteria because their chairman was being treated for gout again.

*A belly band was a small, soft band of cloth that covered the naval cord of newborn infants and kept the drainage from the cord that seeped through the usual covering from staining the baby's clothes. Some people also thought the belly bands kept the naval from protruding and becoming an "outie."

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